OMB Number: 2900-0517
Estimated burden: 6 minutes

Department of Veterans Affairs

OTHER HEALTH INSURANCE (OHI) CERTIFICATION

CHAMPVA CENTER PO BOX 65023 DENVER CO 80206-5023 800-733-8387

Except for Medicaid and policies purchased exclusively for the purpose of supplementing CHAMPVA benefits, CHAMPVA by law is always the secondary payor of health care benefits. As part of our efforts to coordinate benefits among all involved insurance/benefit plans, **COMPLETION AND RETURN OF THIS OHI CERTIFICATION IS REQUIRED.** To avoid claim delays, submit this form within 10 days of receipt. For clarification, the following definitions are provided.

- Primary policies/payors include insurance plans such as those available through employment or privately purchased.
- Supplemental policies, although privately purchased, are those that are designed to pay only after the primary policy.

SECTION I - BENEFICIARY INFORMATION

List all CHAMPVA eligible family members, their Social Security and A-Card Numbers (continue on back if needed)

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NO.	CHAMPVA A-CARD NO.
1.		A-
2.		A-
3.		A-
4.		A-
5.		A-
6.		A-

SECTION II - INSURANCE INFORMATION (includes both primary and supplemental policies)

ARE ANY OF THESE INDIVIDUALS COVERED BY OTHER PRIMARY OR SECONDARY HEALTH INSURANCE.

☐ NO ☐ YES If "NO", go to Section III; otherwise, complete the following.

NAME AND ADDRESS OF OHI (continue on back if needed)	PERIOD COVERED (mo/day/yr) FROM TO IS THIS A SUPPLEMENTAL POLICY (see definition above) ☐ NO ☐ YES
OHI POLICY NO.	OHI PHONE NO. ( )

LIST THOSE FAMILY MEMBERS IDENTIFIED IN SECTION I WHO ARE COVERED BY THIS OHI (continue on back if needed)

1.	3.	5.
2.	4.	6.

SECTION III - MEDICARE INFORMATION

ARE ANY FAMILY MEMBERS IDENTIFIED IN SECTION I COVERED BY MEDICARE ☐ NO ☐ YES

If "NO", go to Section IV; otherwise, complete the following.

NAMES OF MEDICARE ELIGIBLE FAMILY MEMBERS OTHER THAN SPONSOR (continue on back if needed)	PART A COVERAGE (circle one)	PART B COVERAGE (circle one)	EFFECTIVE DATE (mo/day/yr)	HEALTH INSURANCE CLAIM NUMBER
1.	NO YES	NO YES		
2.	NO YES	NO YES		

SECTION IV - CERTIFICATION (to be completed by sponsor, spouse, or legal guardian)

I certify that the above information is correct to the best of my knowledge and belief. If there should be any change in insurance status for me or any other CHAMPVA eligible family member, I will promptly notify the CHAMPVA Center.

SIGNATURE	SIGNER'S A-CARD NUMBER (if applicable)	DATE
ADDRESS(ES) OF BENEFICIARIES IN SECTION I (continue on back if needed) CHECK IF NEW ☐		DAY TELEPHONE NUMBER ( ) EVENING TELEPHONE NUMBER ( )

RETURN THIS SEPARATELY TO ABOVE ADDRESS. DO NOT ENCLOSE CLAIMS OR CORRESPONDENCE.

PRIVACY ACT: This information is solicited under Title 38 USC; 44 USC 3101; 10 USC 1079 and 1086; 41 CFR 104 and Executive Order 9397, to evaluate eligibility and coordinate benefits when other health insurance exists. Disclosure is voluntary, but failure to provide the information may result in delay and/or denial of future CHAMPVA benefit claims. Failure to furnish this information will have no adverse impact on any other benefits to which you may be entitled.

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (045A4), 810 Vermont Avenue NW, Washington DC 20420.